Watch Out for Escape

By FCC (SW) Barry G. Hardman

A ship—pierside in homeport—just had completed a main-space fire drill, and word was passed to re-stow all gear. However, word had not yet been passed to set modified material-condition Zebra.

A petty officer second class, whose GQ station was in the close-in weapons system (CIWS) mount-22 equipment room, wanted to get a "jump" on setting modified Zebra in his spaces. The route to and from the equipment room passed through the escape trunk (the trunk covered six decks from top to bottom) of main engineroom (MER) 2. The trunk has hinged deck-gratings at major platforms.

This is the "guilty" quick-acting water-tight door: The mishap victim stepped through it to return to his space and fell four decks. The grating is shown in its normal down position.

During the past four years, this Sailor had become quite familiar with the route through the trunk to his space. Thus, after exiting the CIWS equipment room following GQ, he climbed 15 feet down the escape trunk and exited through a water-tight door (WTD). He didn't notice fire-party members had left "up" the hinged grating after completing the drill.

The petty officer made his modified-Zebra report to central control and began to return to his space. He opened the WTD to the MER 2 escape

The grating is shown in its up position, as it was left following the drill. It should have been returned to its down position

This is the grating's normal position. Unfortunately, it wasn't returned to this position when the fire party left the space after GQ had ended.

Trunk Gratings!

Looking up from where the mishap victim landed, one can easily see how far he fell. The grating —in its down position—is visible.

This is looking down from the door through which the mishap victim stepped and fell (the lower half of the door opening is visible in the top of the photograph).

trunk and stepped in, expecting to set foot on the safety grating. He either forgot (or maybe hadn't noticed when exiting the trunk to make his report to central control) that the grating was up, and he fell four decks (30 feet) down the trunk.

"Medical emergency, medical emergency! Medical-response team provide to the main engineroom!"

Fortunately, the Sailor never hit a bulkhead or any other obstructions during his fall and was able to land on his feet. Though this landing probably saved his life, his injuries were severe: fractures to his right heel, left ankle, right foot and lumbar spine. He became a permanent loss to his command and is on limited duty.

Several lessons can be learned from this mishap, but none of them are new.

First, always look where you are going. This Sailor would not have been injured had he practiced situational awareness and paid closer attention to his environment, such as noticing the hinged safety grating was up. Since he had traveled this route for four years, his familiarity with it made him complacent, and he was less than 100-percent aware of his surroundings and his actions.

Second, safety-related equipment always must be returned to the primary position for which it was designed. The hinged gratings were installed to offer easy passage across the escape trunk and were meant to be left in the down position. However, the hinged design enabled them to be folded up to provide unimpeded escape up the trunk from MER 2. The fire party's failure to properly re-stow, or put down, the grating created the unsafe condition that led to a shipmate's injuries.

A third lesson is that training-team members must monitor an entire training environment to avoid or—if necessary—to correct potentially hazardous situations. Training team members cannot always be everywhere, but they constantly must be aware of changes and should monitor all areas of the ship a drill affects.

Take your time, look where you are going, and—if you're a supervisor—actively supervise your people, especially during and after a drill. Also take it to heart when the word is passed, "Restow all gear."